MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

March 20-21, 2003

June post-acute care chapter

ISSUE: Commissioners have expressed interest in several issues regarding post-acute care that are supplementary to our work on updating Medicare payments. Commissioners have questioned whether Medicare should pay for care in long-term care hospitals (LTCHs). They have requested more information on the differences between freestanding and hospital-based skilled nursing facilities (SNFs). Finally, Commissioners have requested information on how patterns of care have changed following the implementation of prospective payment systems for post-acute care sectors.

KEY POINTS: The post-acute care chapter will include three main sections with preliminary results from analyses conducted to answer each of these questions. The attached document is a brief introduction to the chapter.

ACTION: Commissioners may wish to comment on the introduction to the Chapter.

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Comparison of freestanding and hospital-based skilled nursing facilities, by types of patients, use, and costs

ISSUE: Policymakers face a difficult set of questions when considering how Medicare should pay for care in skilled nursing facilities (SNFs), particularly given that the financial performance under the SNF prospective payment system appears to be so different between hospital-based and freestanding SNFs. MedPAC projects the Medicare margin for hospital-based SNFs in fiscal year 2003 to be –36 percent, while the Medicare margin for freestanding SNFs in the same year is 11 percent. This raises the following questions: How do hospital-based and freestanding SNFs differ and why? How do they differ according to the types of beneficiaries they treat, the care they provide, and the costs of that care? If hospital-based SNFs have higher costs than freestanding SNFs, are these higher costs associated with enhanced quality of care for specific groups of beneficiaries? We will explore these questions in this analysis.

KEY POINTS: At this meeting, staff will present results of analyses conducted on data from a database of all SNF stays from 1996 through July 2001, which links SNF claims data to patients' corresponding hospital claims, patients' MDS 2.0 (patient assessment) variables, and characteristics of the SNF provider (e.g., provider's location by state and by MSA, ownership, certification, number of beds, and affiliation with a national chain). Here we present preliminary information from fiscal year 2000, by type of facility:

- The demographic characteristics of beneficiaries treated in skilled nursing facilities appear to be similar between hospital-based and freestanding SNFs.
- These demographic characteristics do not appear to have changed much between 1994 and 2000.
- The DRGs of patients treated in freestanding and hospital-based SNFs are very similar, at least in the 20 most common DRGs treated in these facilities, and these DRGs do not appear to have changed very much between 1994 and 2000.
- The average numbers of Medicare-covered days in both freestanding and hospital-based SNFs appear to have declined by 17 and 18 percent, respectively, between 1994 and 2000.
- The average number of Medicare covered days in hospital-based SNFs is consistently about half that in freestanding SNFs, in both 1994 and 2000.
- Medicare payments to SNFs, by type of facility, will also be discussed at this meeting.

ACTION: Staff would appreciate feedback on the direction of this analysis. We will return in April with further analysis of these issues and additional information on the quality of care in SNFs. This analysis will be included in the post-acute care chapter in the June 2003 report.

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MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

March 20-21, 2003

Patterns of post-acute care use pre- and post-PPS

ISSUE: The Balanced Budget Act of 1997 and subsequent legislation mandated the use of prospective payment systems for most post-acute care services, including skilled nursing facility care, home health services, inpatient services in rehabilitation facilities, and services furnished in long-term care hospitals. MedPAC is interested in assessing the impact of these changes on beneficiaries' access to care. One of the goals of Medicare payment policy is to align payments with the efficient costs of providers and, in so doing, help ensure beneficiaries' access to high-quality health care services.

KEY POINTS: The attached report, authored by Direct Research, LLC, compares patterns of post-acute care use in 1996 and 2001. Key findings include:

- Medicare spending for post-acute care services declined by almost 10 percent between 1996 to 2001. This reduction was due to a 50 percent decline in spending for home health services. The total number of episodes and spending increased for those episodes not involving home health services. For all types of post-acute care, the average length of an episode and the number of episodes per beneficiary declined between 1996 and 2001.

- Between 1996 and 2001, there was a substantial leveling of per-capita spending across states. The highest-cost states in 1996 had the greatest reductions in total episodes, days of care, and post-acute care spending in 2001. Conversely, the ten lowest-cost states in 1996 had the smallest reductions in the number of episodes and days of care and the largest increase in post-acute care spending in 2001.

- Although the total number of post-acute care episodes following discharge from acute-care hospitals declined overall, the declines were not uniform across DRGs. Use of post-acute care increased for those DRGs with the highest rates of post-acute use in 1996. On average, the lower the rate of post-acute care use for a DRG in 1996, the proportionately greater the decline in the use of post-acute care services between 1996 and 2001.

- Episodes of home health care for beneficiaries who were not discharged from an acute-care hospital declined by more than 50 percent between 1996 and 2001, more than the decline in total post-acute episodes. Reductions were disproportionately concentrated among beneficiaries with low likelihood of use based on their demographics, comorbidities, and 1996 patterns of care.

ACTION: Commissioners should comment on the methods, findings, and conclusions in the attached report. The results of this analysis will be included in a chapter examining post-acute care services planned for the June 2003 report.

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